VERMONT INDEPENDENT LIVING ASSESSMENT
COVER SHEET

Directions: *Complete pages 1-9 for all AAA services, Homemaker program, Medicaid Waiver, Adult Day, ASP, and HASS program.* ***Arrow ∧ indicates that the question is to be answered by the individual only.*** *For all other questions, if the individual is unable to answer questions, obtain information from family/caregiver(s) or legal representative(s) as necessary with appropriate authorization to release information. Highlighted "Assessor Action" notes appear when action may be necessary.*

A. INDIVIDUAL IDENTIFICATION

0. ILA being completed for which program: A. ☐ Adult Day B. ☐ ASP C. ☐ HASS D. ☐ Homemaker E. ☐ Medicaid Waiver (CFC) F. ☐ AAA Services (NAPIS) G. ☐ Other H: ☐ Dementia Respite

1. Date of Assessment: _____ 2. Unique ID# _____

3. Name: _____
a. *(Last)* *b. (First)* *c. (M.I.)*

4. Also known as: _____
a. *(Last)* *b. (First)* *c. (M.I.)*

5. Phone _____ 6. SS# ___ ___ ___ ___ ___ ___ ___ ___ ___

7. DOB _____ - _____ - _____ 8. Age ____ 9. Gender ☐ Male ☐ Female
Month *Day* *Year*

10. Mailing Address:
a. Street/P.O. Box _____
b. City/Town _____
c. State _____ d. Zip _____

11. Residence *(if different than mailing)*:
a. Street _____
b. City/Town _____
c. State _____

B. EMERGENCY CONTACT INFORMATION

1. Spouse/Partner: _____
a. (Name) *b. (Phone)*

2. Primary Physician: _____
a. (Name) *b. (Phone)*

3. Friend or relative (other than spouse/partner) to contact in case of an emergency:

_____/_____
a. *(Name)* *b. (Relationship)* *c. (Work Phone)* *d. (Home Phone)*

C. DIRECTIONS TO HOME

SECTION 1: Intake

A. ASSESSMENT INFORMATION

Date: _____ 1. A. ☐Initial Assess B. ☐Reassessment C. ☐Update

2. Individual's reason for requesting help: _____

3. Where interviewed:
A. ☐Home B. ☐Hospital C. ☐Nursing Home D. ☐Adult Day E. ☐Other _____

4. Did someone help the individual or answer questions for the individual? A. ☐Yes B. ☐No

5. a. If "Yes", helper's name: _____ b. Helper's relationship: _____

6. Primary language: _____

7. Communication/Language assistance needed for assessment? A. ☐Yes B. ☐No

8. If "Yes", type of assistance: _____

9. ILA completed by: _____ 10. Agency: _____

B. LEGAL REPRESENTATIVE

Check all that apply:

a. Yes (✓)	b. Name	c. Phone (W	d. Phone (H)
1. ☐Power of Attorney			
2. ☐Representative Payee			
3. ☐Legal Guardian			
4. ☐*DPOA for Health Care			
5. ☐*Living Will/ *Copy held by:*			

6. *If no DPOA or Living Will, was information provided about advance directives? A. ☐Yes B. ☐ No

C. DEMOGRAPHICS

1. What is your marital status?
A. ☐ single C. ☐civil union E. ☐ separated
B. ☐ married D. ☐ widowed F. ☐ divorced G. ☐ information unavailable

2a. What is your race or ethnic background? Choose one.
A. ☐White E. ☐Hispanic
B. ☐African-American F. ☐info. unavailable
C. ☐Asian or Pacific Island G. ☐Other:_____
D. ☐American Indian/Alaskan Native

2b. What is your ethnicity? Choose one.
A. ☐ Not Hispanic or Latino B.☐ Hispanic or Latino C.☐ Unknown

2c. What is your race? Choose multiple
A. ☐ Non-Minority (White-non-Hispanic) B. ☐White-Hispanic C. ☐Black African-American
D. ☐American Indian/Alaskan Native E. ☐Asian F. ☐Native Hawaiian/ other Pacific Island G. ☐Unknown
H. ☐Other:_____

Individual's Initials _____

3. Do you live in:
   - A. ☐ house
   - B. ☐ mobile home
   - C. ☐ private apartment
   - D. ☐ apartment in senior housing
   - E. ☐ assisted living residence
   - F. ☐ residential care home
   - G. ☐ nursing home
   - H. ☐ information unavailable
   - I. ☐ other (describe)_____

4. Do you live:
   - A. ☐ alone
   - B. ☐ with spouse/partner
   - C. ☐ with spouse and child
   - D. ☐ with child or children (including adult child)
   - E. ☐ with others _____

5. Are you currently employed? A. ☐ Yes B. ☐ No

6. How many related people reside together in your household (counting yourself)?
   A. ☐ 1 person B. ☐ 2 people C. ☐ 3 people D. ☐ 4 or more E. ☐ info. Unavailable

7a. What is your Household estimated total gross monthly income? .$ _ _,_ _ _ .00

7b. What is your Individual estimated total gross monthly income? .$ _ _,_ _ _ .00

8. Is the individual's gross income below the current federal poverty level? *(review current federal poverty guidelines)*
   A. ☐ Yes B. ☐ No C. ☐ information unavailable/unknown

D. HEALTH RELATED QUESTIONS

D1. General Questions

1. How do you rate your health? Would you say that it is excellent, good, fair, or poor?
   A. ☐ Excellent B. ☐ Good C. ☐ Fair D. ☐ Poor E. ☐ No response

2. Were you admitted to a hospital for any reason in the last 30 days? A. ☐ Yes B. ☐ No

3. In the past year, how many times have you stayed overnight in a hospital?
   A. ☐ not at all B. ☐ one time C. ☐ 2 or 3 times D. ☐ more than 3 times

4. Have you ever stayed in a nursing home, residential care home or other institution (including Brandon Training School and Vermont State Hospital)? A. ☐ Yes B. ☐ No

5. Have you fallen in the last 3 months? A. ☐ Yes B. ☐ No

6. Do you use a walker or four-prong cane (or equivalent), at least some of the time, to get around? A. ☐ Yes B. ☐ No

7. Do you use a wheelchair, at least some of the time, to get around? A. ☐ Yes B. ☐ No

8. In the past month how many days a week have you usually gone out of the house/building where you live?
   A. ☐ Two or more days a week B. ☐ One day a week or less

9. How many days a week are you physically active for at least 30 minutes? This includes any activity that causes small increases in breathing or heart rate that you do for at least 10 minutes at a time. (Such as walking, gardening, housework, dancing.) _____ days/week

Individual's Initials _____

10. Do you **currently** have any of the following medical conditions or problems?

Skip #10 if completing Section 5: Health Assessment

	A. Yes	B. No		A. Yes	B. No
a. heart condition			l. ankle/leg swelling		
b. arthritis			m. urinary problems		
c. diabetes			n. speech problems		
d. cancer			o. hearing problems		
e stroke			p. vision problems		
f. neurological condition			q. dementia (non-Alzheimer's)		
g. breathing condition			r. depression		
h. digestive problems			s. mental health condition		
i. muscle or bone problems			t. anxiety		
j. chronic pain			u. OTHER:		
k. chronic weakness/fatigue			v. Alzheimer's Disease		

11. How many prescription medications do you take? ☐

D2. Functional Needs ***SKIP ADL/IADL checklists if completing Section 6: Functional Assessment***

0 = **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
1 = **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
2 = **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
3 = **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
4 = **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
8 = Activity did not occur (as defined) in last 7 days **–OR-** Unknown

A. ADL checklist

CAN YOU:	0 Independent	1 Supervision	2 Limited Assist	3 Extensive Assist	4 Total Dependence	8 Did not occur
1. dress?						
2. bathe?						
3. manage personal hygiene?						
4. move/position your body while in bed?						
5. use the toilet?						
6. use adaptive devices?						
7. move to/from a bed or chair?						
8. move between locations in your home?						
9. eat?						

B. IADL checklist

CAN YOU:	0 Independent	1 Done with Help	2 Done by Others	8 Did not occur	ADL/IADL Unmet Needs/Comments
1. use the telephone?					
2. prepare your own meals?					
3. manage medication(s)?					
4. manage money?					
5. manage household maintenance?					
6. perform housekeeping tasks?					
7. perform laundry tasks?					
8. do your shopping?					
9. use transportation?					
10. care for equipment?					

18. Do you need any of the following new, repaired or additional devices or home modifications to help you to continue to stay in your home? *(Check all that apply)*

A. ☐ Eyeglasses
B. ☐ Cane or walker
C. ☐ Wheelchair
D. ☐ Assistive eating devices
E. ☐ Assistive dressing devices
F. ☐ Hearing aid
G. ☐ Dentures
H. ☐ Ramp
I. ☐ Doorways widened
J. ☐ Kitchen/bathroom modifications
K. ☐ Other:_____
L. ☐ NONE OF THE ABOVE

D3. Emotional Health

Script for #1-5 (optional) *"Your emotional health is just as important as your physical health. We've just reviewed your current physical health conditions and now I'd like to review your current emotional health."*

1. Do you feel you have enough contact with family? A. ☐Yes B. ☐ No C. ☐No response
2. Do you feel you have enough contact with friends? A. ☐Yes B. ☐ No C. ☐No response

During this past month:

3. *Have you **often** felt downhearted or blue? A. ☐Yes B. ☐No C. ☐No response
4. *Have you been anxious a lot or bothered by your nerves? A. ☐Yes B. ☐No C. ☐No response
5. *Have you felt hopeless or helpless at all? A. ☐Yes B. ☐No C. ☐No response

If "Yes" to questions #3, 4 or5, complete Section 4: Emotional/Behavioral/Cognitive Status, A. Emotional Well-Being, page 12.

D4. Cognitive Orientation

Script for #1-4 (optional) *"Now I'd like to ask a few questions to see how well you're keeping track of time (or of things). For example: "*

1. Could you please tell me what year it is? A. ☐correct B. ☐incorrect C. ☐No response
2. Could you please tell me what month it is? A. ☐correct B. ☐incorrect C. ☐No response
3. Could you please tell me what day of the week it is? A. ☐correct B. ☐incorrect C. ☐No response

4. When you make a decision about something, in general how do you do it?
   A. ☐Independently and alone
   B. ☐Independently after talking it over with family or friends
   C. ☐Usually follow advice of family/friends
   D. ☐I let other people make decisions for me.
   E. ☐No response

◈Assessor Action◈

- *HEALTH: If significant medical issues are apparent, discuss and make appropriate referral/s to physician, home health agency, or other health professional(s).*
- *FUNCTIONAL NEEDS: If help needed with ADLs, IADLs, assistive devices or home modifications, discuss and make appropriate referrals for assistance.*
- *EMOTIONAL HEALTH: For emotional health issues, consider options for Area Agency on Aging Eldercare Clinician, Home Health social services, community mental health, or other counseling/mental health professional.*
- *COGNITION: If "incorrect" answer to cognitive orientation questions, consider referral/s to physician, mental health professional, memory clinic, etc.*

Individual's Initials _____

E. *The NSI DETERMINE Your Nutritional Health Checklist

Directions: *Read the statements below. Circle "Yes" or "No". Add up the "Yes" answers and check the nutrition score.*

Nutrition Checklist	A. Yes	B. No
1. Have you made changes in lifelong eating habits because of health problems? (such as diabetes, high blood pressure, etc.)	2	0
2. Do you eat fewer than 2 complete meals a day?	3	0
3. Do you eat fewer than 5 servings (1/2 cup each) of fruit or vegetables every day?	1	0
4. Do you have fewer than 2 servings of dairy products (such as milk, yogurt, cheese) or tofu every day?	1	0
5. Do you have **any** of the following problems that make it difficult for you to eat? Biting___ Chewing___ Swallowing___	2	0
6. Are there times when you do not have enough money to buy the food you need?	4	0
7. Do you eat most meals alone?	1	0
8. Do you take 3 or more prescribed or over-the-counter medications each day? (including aspirin, laxatives, antacids, herbs, inhalers, etc.)	1	0
9. Have you lost or gained 10 pounds or more in the last 6 months without trying? Loss___ Gain___	2	0
10. Are there times when you are not physically able to do one or more of the following? Shop for food___ Cook___ Eat on your own___	2	0
11. Do you have 3 or more drinks of beer, wine or liquor almost every day?	2	0
12. **Total "Yes" Score**		

What does your total "Yes" score mean? If it is:

0– 2 **Good!** Recheck your nutritional score in 6 months.

3– 5 **You are at moderate nutritional risk.** See what you can do to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center, health department and/or physician can help. Recheck your nutritional score in 3 months.

6+ **You are at high nutritional risk.** You may want to talk with your doctor, dietitian or other qualified health or social services professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.

***Adapted from the *DETERMINE Your Nutritional Health* Checklist developed by the Nutrition Screening Initiative**

Additional Nutrition Questions:

13. About how tall are you without your shoes? A. _____ inches B. ☐ info. unavailable

14. About how much do you weigh without your shoes? A. _____ pounds B. ☐ info. unavailable

15. Do you drink at least six (6) glasses of water, milk, fruit juice or decaffeinated beverage (excluding alcohol) each day? (one glass = 8 oz) A. ☐Yes B. ☐No C. ☐ info. unavailable

16. Do you eat at least two (2) servings of protein rich foods each day? (meat, fish, poultry, nuts, or legumes) A. ☐Yes B. ☐No C. ☐ info. unavailable

◇*Assessor Action*◇

If the individual is at "high nutritional risk" per the NSI checklist, or has other nutritional issues, discuss and recommend appropriate referrals to a registered dietician (AAA or Home Health), physician, or other qualified professional(s).

Individual's Initials _____

F. FINANCIAL RESOURCES

Directions: ***Complete only information necessary for program participation.***

1. Monthly Income:

Source	1. Individual	2. Spouse
a. Social Security	$	$
b. SSI	$	$
c. Retirement/Pension	$	$
d. Interest	$	$
e. VA Benefits	$	$
f. Wages/Salaries/Earnings	$	$
g. Other	$	$
Total Income:	$	$

2. Monthly Expenses:

a. Rent / Mortgage	$
b. Property Tax	$
c. Heat	$
d. Utilities	$
e. House Insurance	$
f. Telephone	$
g. Medical Expenses	$
h. Other:	$
i. Other:	$
Total Expenses:	$

3. Savings/Assets:

TYPE	1. Bank/Institution	2. Account No.	3. Amount
a. Checking			$
b. Savings			$
c. CD			$
d. Burial Account			$
e. Life Insurance			$ (cash value)
f. Other			$
g. Other			$

4. Health Insurance: (check all that apply)

Yes	No			
		a. Medicare A	Effective date:	Medicare #
		b. Medicare B	Effective date:	Mo. Premium: $
		c. Medigap	Company:	Mo. Premium: $
		d. LTC Insurance	Company:	Mo. Premium$
		e. Other		

Comments:

Individual's Initials _____

G. SERVICE/PROGRAM CHECKLIST *Refer to ILA Manual pages 25-32 for service description.*

	a. Check all Services/Programs that apply.	b. Want to Apply (✓)
Home Health Services (HH)	A. ☐ Home Health Aide (LNA)	A. ☐
	B. ☐ Homemaker	B. ☐
	C. ☐ Hospice Services	C. ☐
	D. ☐ Nursing Services (RN)	D. ☐
	E. ☐ Social Work Services	E. ☐
	F. ☐ Therapy (check ☐ PT, ☐ OT, ☐ ST)	F. ☐
Community-Based Care Programs CBC)	G. ☐ Adult Day Services/Day Health Rehab	G. ☐
	H. ☐ Attendant Services Program	H. ☐
	I. ☐ Developmental Disability Services	I. ☐
	J. ☐ Medicaid Waiver (HB/ERC)	J. ☐
	K. ☐ Medicaid High-Tech Services	K. ☐
	L. ☐ Traumatic Brain Injury Waiver	L. ☐
Nutrition Services (NUT)	M. ☐ Commodity Supplemental Food Program	M. ☐
	N. ☐ Congregate Meals (Sr. Center)	N. ☐
	O. ☐ Emergency Food Shelf/Pantry	O. ☐
	P. ☐ Home Delivered Meals	P. ☐
	Q. ☐ Senior Farmer's Market Nutrition Program	Q. ☐
Social Service Programs (SSP)	R. ☐ Area Agency on Aging Case Management	R. ☐
	S. ☐ Community Action Program (CAP)	S. ☐
	T. ☐ Community Mental Health Services	T. ☐
	U. ☐ Dementia Respite Grant Program/NFCSP Grant	U. ☐
	V. ☐ Eldercare Clinician	V. ☐
	W. ☐ Job Counseling/Vocational Rehabilitation	W. ☐
	X. ☐ Office of Public Guardian	X. ☐
	Y. ☐ Senior Companion Program	Y. ☐
	Z. ☐ VCIL Peer Counseling	Z. ☐
	AA. ☐ VT Assoc. for the Blind and Visually Impaired	AA. ☐
	BB. ☐ VT Legal Aid Services	BB. ☐
Housing Programs (HP)	CC. ☐ Assistive Community Care Services (ACCS)	CC. ☐
	DD. ☐ Housing and Supportive Services (HASS)	DD. ☐
	EE. ☐ Section 8 Voucher (Housing Choice)	EE. ☐
	FF. ☐ Subsidized Housing	FF. ☐
DCF Benefit Programs (DCF)	GG. ☐ Aid to Needy Families with Children	GG. ☐
	HH. ☐ Essential Persons Program	HH. ☐
	II. ☐ Food Stamp Program	II. ☐
	JJ. ☐ Fuel Assistance Program	JJ. ☐
	KK. ☐ General Assistance Program	KK. ☐
	LL. ☐ Medicaid	LL. ☐
	MM. ☐ QMB/SLMB	MM. ☐
	NN. ☐ Telephone "Lifeline" Discount	NN. ☐
	OO. ☐ VHAP (VT Health Access Program)	OO. ☐
	PP. ☐ VHAP Pharmacy	PP. ☐
	QQ. ☐ V-Script	QQ. ☐
Other Services	RR. ☐ Emergency Response System	RR. ☐
	SS. ☐ Supplemental Security Income (SSI)	SS. ☐
	TT. ☐ Veterans Benefits	TT. ☐
	UU. ☐ Weatherization Program (CAP)	UU. ☐
	VV. ☐ NONE OF THE ABOVE	

H. "SELF NEGLECT", ABUSE, NEGLECT, AND EXPLOITATION SCREENING

Directions: *The following information may be obtained from the assessor's observation or reports from the individual, involved family, friends or providers (i.e. Home Health Agency, physician, etc.).*

1. Is the individual refusing services and putting him/herself or others at risk of harm?
   A. ☐ Yes B. ☐ No C. ☐ info. unavailable

2. Is the individual exhibiting dangerous behaviors and putting him/herself or others at risk of harm?
   A. ☐ Yes B. ☐ No C. ☐ info. unavailable

3. Is the individual making clear, informed decisions about his/her needs and appear to understand the consequences of these decisions?
   A. ☐ Yes B. ☐ No C. ☐ info. unavailable

4. Is there evidence (observed or reported) of suspected **abuse, neglect, or exploitation** by another person?
   A. ☐ Yes B. ☐ No C. ☐ info. unavailable

Comments:

◈*Assessor Action*◈

SELF NEGLECT: If the answer to #1 or #2 is "Yes" the individual may be considered "Self-Neglect". Refer individuals 60 and older to the local Area Agency on Aging if necessary (AAA) (1-800-642-5119).Refer individuals under 60 to Adult Protective Services at 1-800-564-1612.

If the answer to #1 or #2 is "Yes" and the answer to # 3 is "Yes", consider a "Negotiated Risk" contract between service providers and the individual.

Make other appropriate referrals regarding "dangerous" behaviors. (i.e. legal, psychiatric, medical, behavioral consult, etc.)

ABUSE / NEGLECT / EXPLOITATION: If the answer to #4 is "Yes", mandated reporters must file a report of abuse, neglect, or exploitation in accordance with Vermont's Adult Abuse Statue (Title 33) within 48 hours to Adult Protective Services at 1-800-564-1612.

SECTION 2: Supportive Assistance

Date:_____ *(Chose One):* ☐Initial Assessment ☐Reassessment ☐Update

Directions: *Complete this section for Medicaid Waiver, Adult Day, ASP. May also complete if SECTION 1: Intake indicates a need for more information. If the individual is unable to answer the following questions, obtain information from family/caregiver or legal representative.*

The following questions are specifically in regards to unpaid caregivers, such as family, friends, volunteers.

1. Who is the primary unpaid person who usually helps you? *(Check one only)*
   - A. ☐Spouse or significant other
   - B. ☐Daughter or son
   - C. ☐Other family member
   - D. ☐Friend, neighbor or community member
   - E. ☐NONE *(If "NONE, go to Section 3: Living Arrangements)*

2. How often do you receive help from this person? *(Check one only)* ***Skip if #3 is NONE.***
   - A. ☐Several times during day and night
   - B. ☐ Several times during day
   - C. ☐Once daily
   - D. ☐Three or more times per week
   - E. ☐One to two times per week
   - F. ☐Less often than weekly
   - G. ☐Unknown

3. What type of help does this person provide? *(Mark all that apply)* ***Skip if #3 is NONE.***
   - A. ☐ADL assistance (e.g., bathing, dressing, toileting, bowel/bladder, eating/feeding)
   - B. ☐ IADL assistance (e.g., meds, meals, housekeeping, laundry, telephone, shopping, finances, transportation)
   - C. ☐Environmental support (housing, home maintenance)
   - D. ☐Psychosocial support (socialization, companionship, recreation)
   - E. ☐Advocates or facilitates individual's participation in appropriate medical care
   - F. ☐Financial agent, power of attorney, or conservator of finance
   - G. ☐Health care agent, conservator of person, or medical power of attorney
   - H. ☐Unknown

4. Record information on primary unpaid caregiver in #1: ***Skip if #1 is NONE.***

_____

a. (Name) *b. (Relationship)* *c. (Phone)*

_____

d. (Address)

Question #5 is to be asked of the primary caregiver identified in question #4a.

5. Which of the following areas are affected by your role as a caregiver?
   - A. ☐job
   - B. ☐finances
   - C. ☐family responsibilities
   - D. ☐physical health
   - E. ☐emotional health
   - F. ☐ other: _____

Comments:

◈Assessor Action◈

If the primary caregiver indicates factors in #5, discuss options for family support services and make appropriate referrals. For further caregiver assessment and planning, consider completing the "Caregiver Self-Assessment Questionnaire".

SECTION 3: Living Environment

Date: _____ *(Chose One):* ☐Initial Assessment ☐Reassessment ☐Update

Directions: *Complete this section for Medicaid Waiver, Adult Day, ASP. May also complete if SECTION 1: Intake indicates a need for more information. If the individual is unable to answer the following questions, mark the following issues that are reported by the family/caregiver(s) observed by the assessor. Be as complete as possible.*

1. Do any of the following issues make it difficult for you to get around your home? *(Mark all that apply)*
   - A. ☐Stairs inside home which must be used by the individual (e.g., to get to toileting, sleeping, eating areas)
   - B. ☐Stairs inside home which are used optionally (e.g., to get to laundry facilities)
   - C. ☐Stairs leading from inside house to outside
   - D. ☐Narrow or obstructed doorways
   - E. ☐Other (specify)_____
   - F. ☐NONE OF THE ABOVE

2. Do any of the following safety issues exist in your home? *(Mark all that apply)*
   - A. ☐Inadequate floor, roof, or windows
   - B. ☐Inadequate lighting
   - C. ☐Unsafe gas/electric appliance
   - D. ☐Inadequate heating
   - E. ☐Inadequate cooling
   - F. ☐Absence of working smoke detectors
   - G. ☐Unsafe floor coverings
   - H. ☐Inadequate stair railings
   - I. ☐Improperly stored hazardous materials
   - J. ☐Lead-based paint
   - K. ☐Other (specify)_____
   - L. ☐NONE OF THE ABOVE

3. Do any of the other following sanitation issues exist in your home? *(Mark all that apply)*
   - A. ☐No running water
   - B. ☐Contaminated water
   - C. ☐No toileting facilities
   - D. ☐Outdoor toileting facilities only
   - E. ☐Inadequate sewage disposal
   - F. ☐Inadequate/improper food storage
   - G. ☐No food refrigeration
   - H. ☐No cooking facilities
   - I. ☐Insects/rodents present
   - J. ☐No scheduled trash pickup
   - K. ☐Cluttered/soiled living area
   - L. ☐Other (specify)_____
   - M. ☐NONE OF THE ABOVE

Comments:

◈Assessor Action◈

If the individual's living arrangements indicate significant safety or health issues, discuss and make appropriate referral(s) for home repair, cleaning, and/or pest extermination.

SECTION 4: Emotional/Behavioral/Cognitive Status

Date:_____ ***(Chose One):*** ☐Initial Assessment ☐Reassessment ☐Update

Directions: *Complete this section for Medicaid Waiver, Adult Day, ASP. May also complete if SECTION 1: Intake indicates a need for more information.*

A. EMOTIONAL WELL-BEING

Complete questions #1- 11 only if the individual answered "Yes" to D3. Emotional Health questions #3, 4, or 5, Section 1: Intake.

"I'd like you to think about your moods and feelings in the last month."

1. Have you felt satisfied with your life? A. ☐Yes B. ☐No C. ☐Sometimes D. ☐No response
2. Have you had a change in your sleeping patterns? A. ☐Yes B. ☐No C. ☐Sometimes D. ☐No response
3. Have you had a change in your appetite? A. ☐Yes B. ☐No C. ☐Sometimes D. ☐No response
4. *Have you often felt depressed, sad or very unhappy? A. ☐Yes B. ☐No C. ☐Sometimes D. ☐No response

***If answer is YES or SOMETIMES to #4, ask the next question. If answer is NO, go to #10.**

5. *Have you thought about harming yourself? A. ☐Yes B. ☐No

***If answer is YES to #5, ask the next questions. If answer is NO, go to #10.**

6. **Do you have a plan? A. ☐Yes B. ☐No
7. **Do you have the means to carry out your plan? A. ☐Yes B. ☐No
8. **Do you intend to carry this out? A. ☐Yes B. ☐No
9. **Have you harmed yourself before? A. ☐Yes B. ☐No

10. Are you currently receiving psychiatric and/or counseling services?
A. ☐ Yes B. ☐ No C. ☐info. unavailable

11. If "Yes", are you receiving services: ☐At home B. ☐In the community C. ☐both

B. BEHAVIORAL STATUS

Directions: *For each question, check one answer for each behavior in last 7 days. Information may be gathered from family, caregiver(s) or assessor's observations.*

1.a. How often does the individual get lost or wander? (Moves with no rational purpose, seemingly oblivious to needs or safety.)
☐0 – Never ☐1 – Less than daily ☐2 – Daily

1.b. In the last 7 days, was the wandering alterable?
☐0 – Behavior was not present -**OR**- was easily altered ☐1 – Behavior was NOT easily altered

2.a. How often is the individual verbally abusive to others? (Others were threatened, screamed at, cursed at.)
☐0 – Never ☐1 – Less than daily ☐2 – Daily

2.b. In the last 7 days, was the verbal abuse alterable?
☐0 – Behavior was not present -**OR**- was easily altered ☐1 – Behavior was NOT easily altered

3.a. How often is the individual physically abusive to others? (Others were hit, shoved, scratched, sexually abused.)
☐0 – Never ☐1 – Less than daily ☐2 – Daily

3.b. In the last 7 days, was the physical abuse alterable?
☐0 – Behavior was not present -**OR**- was easily altered ☐1 – Behavior was NOT easily altered

4.a. How often does the individual exhibit socially inappropriate/disruptive behavior? (Makes disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings.)

☐0 – Never ☐1 – Less than daily ☐2 – Daily

4.b. In the last 7 days, was the socially disruptive behavior alterable?

☐0 – Behavior was not present **-OR-** was easily altered ☐1 – Behavior was NOT easily altered

5.a. How often did the individual display symptoms of resisting care? (Resists taking medications/injections, ADL assistance, or eating.)

☐0 – Never ☐1 – Less than daily ☐2 – Daily

5.b. In the last 7 days, was the resisting care behavior alterable?

☐0 – Behavior was not present **-OR-** was easily altered ☐1 – Behavior was NOT easily altered

C. COGNITIVE STATUS

Directions: *Information may be gathered from family/caregiver(s) or assessor's observations. Check the one answer for each that best describes the individual's cognitive status.*

1. Memory and use of information:
   - A. ☐Does not have difficulty remembering and using information. Does not require directions or reminding from others.
   - B. ☐Has minimal difficulty remembering and using information. Requires direction and reminding from others 1 to 3 times per day. Can follow simple written instructions.
   - C. ☐Has difficulty remembering and using information. Requires direction and reminding from others 4 or more times per day.
   - D. ☐Cannot remember or use information. Requires continual verbal reminding.

2. Global confusion:
   - A. ☐Appropriately responsive to environment.
   - B. ☐Nocturnal confusion on awakening.
   - C. ☐Periodic confusion during daytime.
   - D. ☐Nearly always confused.

3. Verbal communication:
   - A. ☐Speaks normally.
   - B. ☐Minor difficulty with speech or word-finding difficulties.
   - C. ☐Able to carry out only simple conversations.
   - D. ☐Unable to speak coherently or make needs known.

4. Cognitive Skills for Daily Decision-Making
   - A. ☐Independent – decisions consistent/reasonable
   - B. ☐Modified independence – some difficulty in new situations only
   - C. ☐Moderately impaired – decision poor/cues/supervision required
   - D. ☐Severely impaired – never/rarely makes decisions

◈Assessor Action◈

*****If "YES" to Emotional Well-Being questions #6-8, contact the appropriate local crisis authorities immediately. Discuss other psychiatric and/or mental health counseling services and make appropriate referrals. Make appropriate referrals regarding behavioral/cognitive symptoms as necessary.***

SECTION 5: Health Assessment

Date:_____ ***(Chose One):*** ☐Initial Assessment ☐Reassessment ☐Update

Directions*:* *Complete this section for Medicaid Waiver, Adult Day, ASP. May also complete if SECTION 1: Intake indicates a need for more information. If the individual is unable to answer the following questions, obtain information from family/caregiver(s), legal representative and/or medical records.*

A. DIAGNOSIS/CONDITIONS/TREATMENTS

1. **Diagnosis:** List the primary medical diagnosis for which the individual is receiving services/treatments.

Primary Diagnosis: _____

2. **Other Disease Diagnosis:** *Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses.)*

Endocrine/Metabolic/Nutritional
- A. ☐Diabetes mellitus
- B. ☐Hyperthyroidism
- C. ☐Hypothyroidism

Heart/Circulation
- D. ☐Arteriosclerotic heart disease
- E. ☐Cardiac dysrhythmias
- F. ☐Congestive heart failure
- G. ☐Deep vein thrombosis
- H. ☐Hypertension
- I. ☐Hypotension
- J. ☐Peripheral vascular disease
- K. ☐Other cardiovascular disease

Musculoskeletal
- L. ☐Arthritis
- M. ☐Hip fracture
- N. ☐Missing limb
- O. ☐Osteoporosis
- P. ☐Pathological bone fracture

Neurological
- Q. ☐Alzheimer's disease
- R. ☐Aphasia
- S. ☐Cerebral palsy
- T. ☐Cerebrovascular accident (stroke)
- U. ☐Dementia other than Alzheimer's disease
- V. ☐Hemiplegia/hemiparesis
- W. ☐Multiple sclerosis
- X. ☐Paraplegia
- Y. ☐Parkinson's disease
- Z. ☐Quadriplegia
- AA. ☐Seizure disorder
- BB. ☐Transient ischemic attack (TIA)
- CC. ☐Traumatic brain injury

Psychiatric/Mood
- DD. ☐Anxiety disorder
- EE. ☐Depression
- FF. ☐Manic depressive/bipolar disease
- GG. ☐Schizophrenia

Pulmonary
- HH. ☐Asthma
- II. ☐Emphysema/COPD

Sensory
- JJ. ☐Cataracts
- KK. ☐Diabetic retinopathy
- LL. ☐Glaucoma
- MM. ☐Macular degeneration

Other
- NN. ☐Allergies
- OO. ☐Anemia
- PP. ☐Cancer
- QQ. ☐Renal failure
- RR. ☐NONE OF THE ABOVE
- SS. ☐OTHER:
- TT. ☐OTHER:

3. **Infections:** *Check all that apply. If none apply, check the NONE OF THE ABOVE box.*
- A. ☐Antibiotic resistant infection
- B. ☐Clostridium difficile
- C. ☐Conjunctivitis
- D. ☐HIV infection
- E. ☐Pneumonia
- F. ☐Respiratory infection
- G. ☐Septicemia
- H. ☐Sexually transmitted disease
- I. ☐Tuberculosis
- J. ☐Urinary tract infection *in last 30 days*
- K. ☐Viral hepatitis
- L. ☐Wound infection
- M. ☐ OTHER:
- N. ☐ NONE OF THE ABOVE

4. **Problem Conditions:** *Check all problems present in the last 7 days.*

A. ☐ Dehydration
B. ☐ Delusions
C. ☐ Dizziness/Vertigo
D. ☐ Edema
E. ☐ Fever
F. ☐ Internal bleeding
G. ☐ Recurrent lung aspirations ***in last 90 days***
H. ☐ Shortness of breath
I. ☐ Syncope (fainting)
J. ☐ Unsteady gait
K. ☐ Vomiting (recurring)
L. ☐ End stage disease, 6 or fewer months to live
M. ☐ NONE OF THE ABOVE
N. ☐ OTHER:

5. **Special Care/Treatments:** *Check all treatments received during the last 14 days.*

A. ☐ Chemotherapy
B. ☐ Dialysis
C. ☐ IV meds
D. ☐ Intake/output
E. ☐ Monitoring acute medical condition
F. ☐ Ostomy care
G. ☐ Oxygen therapy
H. ☐ Radiation
I. ☐ Suctioning
J. ☐ Tracheostomy Care
K. ☐ Transfusions (specify)
L. ☐ Ventilator or respirator
M. ☐ NONE OF THE ABOVE
N. ☐ OTHER:

6. **Therapies:** *Check all therapies received in last 7 days.*

A. ☐ Speech Therapy
B. ☐ Occupational Therapy
C. ☐ Physical Therapy
D. ☐ Respiratory Therapy
E. ☐ NONE OF THE ABOVE

7. Does the individual currently receive at least 45 minutes/day for at least 3 days week of PT or a combination of PT, ST, or OT? A. ☐ Yes B. ☐ No C. ☐ info. unavailable

8. Check all nutritional issues in the last 7 days. *(Mark all that apply)*

A. ☐ Parenteral/IV
B. ☐ Feeding tube
C. ☐ Mechanically altered diet
D. ☐ Syringe (oral feeding)
E. ☐ Therapeutic diet
F. ☐ Dietary supplement between meals
G. ☐ Plate guard, stabilized built-up utensil, etc.
H. ☐ On a planned weight change program
I. ☐ Oral liquid diet
J. ☐ NONE OF THE ABOVE

9. Check all current high risk factors characterizing this individual. *(Mark all that apply)*

A. ☐ Smoking
B. ☐ Obesity
C. ☐ Alcohol dependency
D. ☐ Drug dependency
E. ☐ Unknown
F. ☐ Other:_____
G. ☐ NONE OF THE ABOVE

B. PAIN STATUS

1. What is the frequency of pain interfering with individual's activity or movement? C*heck one.*
   - A. ☐ Individual has **no** pain or pain does **not** interfere with activity or movement
   - B. ☐ Less often than daily
   - C. ☐ Daily, but not constantly
   - D. ☐ All of the time
   - E. ☐ Info. unavailable

2. Is the individual experiencing pain that is not easily relieved, occurs at least daily, and affects the individual's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity?
   A. ☐ Yes B. ☐ No C. ☐ info. unavailable

C. SKIN STATUS

1.a. Specify the highest stage (1-4) for any pressure ulcer(s) the individual currently has. Specify 0 if no pressure ulcer(s).
Stage: _____

1.b. Specify the highest stage (1-4) for any stasis ulcer(s) the individual currently has. Specify 0 if no pressure ulcer(s).
Stage: _____

Key for Ulcer Stages

Stage 1: A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved

Stage 2: A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

Stage 3: A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.

Stage 4: A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

2. Indicate which of the following skin problems the individual has that requires treatment. *Check all that apply during last 7 days.*
   - A. ☐ Abrasions, bruises
   - B. ☐ Burns (second or third)
   - C. ☐ Open lesions other than ulcers, rashes, cuts (e.g. cancer lesions)
   - D. ☐ Rashes (e.g. intertrigo, eczema, drug rash, heat rash, herpes zoster)
   - E. ☐ Skin desensitized to pain or pressure
   - F. ☐ Skin tears or cuts (other than surgery)
   - G. ☐ Surgical wounds
   - H. ☐ NONE OF THE ABOVE

D. ELIMINATION STATUS

1. Has the individual been treated for a urinary tract infection (UTI) in the last 14 days? A. ☐ Yes B. ☐ No

2. Does the individual have urinary incontinence?
   - A. ☐ Yes
   - B. ☐ No incontinence and no urinary catheter
   - C. ☐ No incontinence, individual has urinary catheter

   If answer is b. or c., go to question #5.

Individual's Initials _____

3. What is the frequency of urinary incontinence?
   - A. ☐ less than once weekly
   - B. ☐ one to three times weekly
   - C. ☐ four to six times weekly
   - D. ☐ one to three times daily
   - E. ☐ four or more times daily

4. When does urinary incontinence occur?
   - A. ☐ during the day only
   - B. ☐ during the night only
   - C. ☐ during the day and night

5. Does the individual have bowel incontinence?
   - A. ☐ Yes
   - B. ☐ No incontinence and no ostomy
   - C. ☐ No incontinence, individual has an ostomy

   If answer is b. or c., go to question #8.

6. What is the frequency of bowel incontinence?
   - A. ☐ less than once weekly
   - B. ☐ one to three times weekly
   - C. ☐ four to six times weekly
   - D. ☐ one to three times daily
   - E. ☐ four or more times daily

7. When does bowel incontinence occur?
   - A. ☐ during the day only
   - B. ☐ during the night only
   - C. ☐ during the day and night

8. Has the individual experienced recurring bouts of diarrhea in the last 7 days?
   - A. ☐ Yes
   - B. ☐ No

9. Has the individual experienced recurring bouts of constipation in the last 7 days?
   - A. ☐ Yes
   - B. ☐ No

Comments:

Name of RN/LPN (*print*):
_____

Agency: _____

Signature of
RN/LPN:_____Date:_____

◈*Assessor Action*◈

Incorporate Health Assessment issues into the appropriate plan for services. Make appropriate referrals for identified unmet health needs.

SECTION 6: Functional Assessment

Date:_____ ☐Initial Assessment ☐Reassessment ☐Update

Directions*: Complete for Medicaid Waiver, ASP and Adult Day. If the individual is unable to answer the following questions, obtain information from family/caregiver(s), service provider(s), and/or assessor's observations.*

A. ACTIVITIES OF DAILY LIVING (ADL's)

1.a. **DRESSING:** During the last 7 days, how would you rate the individual's ability to dress? (Putting on, fastening, and taking off all items of clothing, including donning/removing prosthesis.)

☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

1.b. Select the item for the most support provided for dressing during the last 7 days.

☐0 - No setup or physical help
☐1 - Setup help only
☐2 - One person physical assist
☐3 - Two+ persons physical assist
☐8 - Activity did not occur during entire 7 days –**OR-** Unknown

1.c. What was the individual's level of unmet need for dressing during the last 7 days?

☐A – Need was seldom or never met
☐B – Need was met, no need for additional help
☐C – Unknown

1.d. Dressing Comments:

2.a. **BATHING:** During the last 7 days, how would you rate the individual's ability to perform bathing? (Taking a full-body bath/shower, sponge bath, washing/drying face, hands and perineum. (Excluding back and hair)

☐0 - **Independent:** No help provided
☐1 - **Supervision:** Oversight/cueing only
☐2 - **Limited Assist:** Physical help limited to transfer only
☐3 - **Extensive Assist:** Physical help in part of bathing activity
☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

2.b. Select the item for the most support provided for bathing during the last 7 days.

☐0 - No setup or physical help
☐1 - Setup help only
☐2 - One person physical assist
☐3 - Two+ persons physical assist
☐8 - Activity did not occur during entire 7 days –**OR-** Unknown

2.c. What was the individual's level of unmet need for bathing during the last 7 days?

- ☐ A – Need was seldom or never met
- ☐ B – Need was met, no need for additional help
- ☐ C – Unknown

2.d. Bathing Comments:

3.a. **PERSONAL HYGIENE:** During the last 7 days, how would you rate the individual's ability to perform personal hygiene? (Combing hair, brushing teeth, shaving, washing/drying face, hands, and perineum, EXCLUDE baths and showers.)

- ☐ 0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
- ☐ 1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
- ☐ 2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
- ☐ 3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
- ☐ 4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
- ☐ 8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

3.b. Select the item for the most support provided for personal hygiene during the last 7 days.

- ☐ 0 - No setup or physical help
- ☐ 1 - Setup help only
- ☐ 2 - One person physical assist
- ☐ 3 - Two+ persons physical assist
- ☐ 8 - Activity did not occur during entire 7 days –**OR-** Unknown

3.c. What was the individual's level of unmet need for personal hygiene during the last 7 days?

- ☐ A – Need was seldom or never met
- ☐ B – Need was met, no need for additional help
- ☐ C – Unknown

3.d. Personal Hygiene Comments:

4.a. **BED MOBILITY:** During the last 7 days, how would you rate the individual's ability to perform bed mobility? (Moving to and from lying position, turning side-to-side, and positioning body while in bed.)

- ☐ 0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
- ☐ 1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
- ☐ 2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
- ☐ 3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
- ☐ 4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days

☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

4.b. Select the item for the most support provided for bed mobility during the last 7 days.

☐0 - No setup or physical help
☐1 - Setup help only
☐2 - One person physical assist
☐3 - Two+ persons physical assist
☐8 - Activity did not occur during entire 7 days –**OR-** Unknown

4.c. What was the individual's level of unmet need for bed mobility during the last 7 days?

☐A – Need was seldom or never met
☐B – Need was met, no need for additional help
☐C – Unknown

4.d. Bed Mobility Comments:

5.a. **TOILET USE:** During the last 7 days, how would you rate the individual's ability to perform toilet use? (Using the toilet, commode, bedpan, urinal; transferring on/off toilet, cleansing self, managing incontinence pad(s), managing ostomy or catheter, adjusting clothes.)

☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

5.b. Select the item for the most support provided for toilet use during the last 7 days.

☐0 - No setup or physical help
☐1 - Setup help only
☐2 - One person physical assist
☐3 - Two+ persons physical assist
☐8 - Activity did not occur during entire 7 days –**OR-** Unknown

5.c. What was the individual's level of unmet need for toilet use during the last 7 days?

☐A – Need was seldom or never met
☐B – Need was met, no need for additional help
☐C – Unknown

5.d. Toilet Use Comments:

Individual's Initials _____

6.a. **ADAPTIVE DEVICES:** During the last 7 days, how would you rate the individual's ability to manage putting on and removing braces, splints, and other adaptive devices?

- ☐ 0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
- ☐ 1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
- ☐ 2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
- ☐ 3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
- ☐ 4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
- ☐ 8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

6.b. Select the item for the most support provided for adaptive devices use during the last 7 days.

- ☐ 0 - No setup or physical help
- ☐ 1 - Setup help only
- ☐ 2 - One person physical assist
- ☐ 3 - Two+ persons physical assist
- ☐ 8 - Activity did not occur during entire 7 days –**OR-** Unknown

6.c. What was the individual's level of unmet need for help with adaptive devices during the last 7 days?

- ☐ A – Need was seldom or never met
- ☐ B – Need was met, no need for additional help
- ☐ C – Unknown

6.d. Adaptive Devices Comments

7.a. **TRANSFERRING:** During the last 7 days, how would you rate the individual's ability to perform transferring? (Moving between surfaces – to/from bed, chair, wheelchair, standing position , EXCLUDES to/from bath/toilet.)

- ☐ 0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
- ☐ 1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
- ☐ 2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
- ☐ 3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
- ☐ 4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
- ☐ 8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

7.b. Select the item for the most support provided for transferring during the last 7 days.

- ☐ 0 - No setup or physical help
- ☐ 1 - Setup help only
- ☐ 2 - One person physical assist
- ☐ 3 - Two+ persons physical assist
- ☐ 8 - Activity did not occur during entire 7 days –**OR-** Unknown

7.c. What was the individual's level of unmet need for transferring during the last 7 days?

- ☐ A – Need was seldom or never met
- ☐ B – Need was met, no need for additional help
- ☐ C – Unknown

7.d. Transferring Comments:

Individual's Initials _____

8.a. **MOBILITY:** During the last 7 days, how would you rate the individual's ability to perform mobility in the home? (Moving between locations in his/her home. If in wheelchair, self-sufficiency once in wheelchair.)

- ☐ 0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
- ☐ 1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
- ☐ 2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
- ☐ 3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
- ☐ 4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
- ☐ 8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

8.b. Select the item for the most support provided for mobility during the last 7 days.

- ☐ 0 - No setup or physical help
- ☐ 1 - Setup help only
- ☐ 2 - One person physical assist
- ☐ 3 - Two+ persons physical assist
- ☐ 8 - Activity did not occur during entire 7 days –**OR-** Unknown

8.c. What was the individual's level of unmet need for mobility during the last 7 days?

- ☐ A – Need was seldom or never met
- ☐ B – Need was met, no need for additional help
- ☐ C – Unknown

8.d. Mobility Comments:

9.a. **EATING:** During the last 7 days, how would you rate the individual's ability to perform eating? (Ability to eat and drink (regardless of skill). Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition).)

- ☐ 0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
- ☐ 1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
- ☐ 2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
- ☐ 3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
- ☐ 4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
- ☐ 8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

9.b. Select the item for the most support provided for eating during the last 7 days.

- ☐ 0 - No setup or physical help
- ☐ 1 - Setup help only
- ☐ 2 - One person physical assist
- ☐ 3 - Two+ persons physical assist
- ☐ 8 - Activity did not occur during entire 7 days –**OR-** Unknown

9.c. What was the individual's level of unmet need for eating during the last 7 days?

- ☐ A – Need was seldom or never met
- ☐ B – Need was met, no need for additional help
- ☐ C – Unknown

9.d. Eating Comments:

B. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL's)

1.a. **PHONE USE:** During the last 7 days, how would you rate the individual's ability to perform phone use? (Answering the phone, dialing numbers, and effectively using the telephone to communicate.)

- ☐ 0 - **Independent:** No help provided (With/without assistive devices)
- ☐ 1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐ 2 – **Done by Others**: Full caregiver assistance.
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

1.b. Select the item for the most support provided for phone use during the last 7 days.

- ☐ 0 – No support provided
- ☐ 1 – Supervision/Cueing only
- ☐ 2 – Setup only
- ☐ 3 – Physical assistance provided
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

1.c. What was the individual's level of unmet need for phone use during the last 7 days?

- ☐ A – Need was seldom or never met
- ☐ B – Need was met, no need for additional help
- ☐ C – Unknown

1.d. Phone Use Comments:

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2. a. **MEAL PREPARATION:** During the last 7 days, how would you rate the individual's ability to perform meal preparation? (Planning and preparing light meals or reheating delivered meals.)

- ☐ 0 - **Independent:** No help provided (With/without assistive devices)
- ☐ 1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐ 2 – **Done by Others**: Full caregiver assistance.
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

2.b. Select the item for the most support provided for meal prep during the last 7 days.

- ☐ 0 – No support provided
- ☐ 1 – Supervision/Cueing only
- ☐ 2 – Setup only
- ☐ 3 – Physical assistance provided
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

2.c. What was the individual's level of unmet need for meal prep during the last 7 days?

- ☐ A – Need was seldom or never met
- ☐ B – Need was met, no need for additional help
- ☐ C – Unknown

2.d. Meal Prep Comments:

3.a. **MEDICATIONS:** During the last 7 days, how would you rate the individual's ability to manage medications? (Preparing and taking all prescribed and over the counter medications reliably and safely, including the correct dosage at appropriate times/intervals.)

- ☐ 0 - **Independent:** No help provided (With/without assistive devices)
- ☐ 1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐ 2 – **Done by Others**: Full caregiver assistance.
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

3.b. Select the item for the most support provided for medication management during the last 7 days.

- ☐ 0 – No support provided
- ☐ 1 – Supervision/Cueing only
- ☐ 2 – Setup only
- ☐ 3 – Physical assistance provided
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

3.c. What was the individual's level of unmet need for medication management during the last 7 days?

- ☐ A – Need was seldom or never met
- ☐ B – Need was met, no need for additional help
- ☐ C – Unknown

3.d. Medication Management Comments:

4.a. **MONEY MANAGEMENT:** During the last 7 days, how would you rate the individual's ability to perform money management? (Payment of bills, managing checkbook/account(s), being aware of potential exploitation, budgets, plans for emergencies, etc.)

- ☐ 0 - **Independent:** No help provided (With/without assistive devices)
- ☐ 1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐ 2 – **Done by Others**: Full caregiver assistance.
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

4.b. Select the item for the most support provided for money management during the last 7 days.

- ☐ 0 – No support provided
- ☐ 1 – Supervision/Cueing only
- ☐ 2 – Setup only
- ☐ 3 – Physical assistance provided
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

4.c. What was the individual's level of unmet need for money management during the last 7 days?

- ☐ A – Need was seldom or never met
- ☐ B – Need was met, no need for additional help
- ☐ C – Unknown

4.d. Money Management Comments:

5.a. **HOUSEHOLD MAINTENANCE:** During the last 7 days, how would you rate the individual's ability to perform household maintenance? (Chores such as washing windows, shoveling snow, taking out the garbage and scrubbing floors.)

- ☐ 0 - **Independent:** No help provided (With/without assistive devices)
- ☐ 1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐ 2 – **Done by Others**: Full caregiver assistance.
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

5.b. Select the item for the most support provided for household maintenance during the last 7 days.

- ☐ 0 – No support provided
- ☐ 1 – Supervision/Cueing only
- ☐ 2 – Setup only
- ☐ 3 – Physical assistance provided
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

5.c. What was the individual's level of unmet need for household maintenance during the last 7 days?

- ☐ A – Need was seldom or never met
- ☐ B – Need was met, no need for additional help
- ☐ C – Unknown

5.d. Household Maintenance Comments:

6.a. **HOUSEKEEPING:** During the last 7 days, how would you rate the individual's ability to perform housekeeping? (Housekeeping tasks such as dusting, sweeping, vacuuming, dishes, light mop, and picking up.)

- ☐ 0 - **Independent:** No help provided (With/without assistive devices)
- ☐ 1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐ 2 – **Done by Others**: Full caregiver assistance.
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

6.b. Select the item for the most support provided for housekeeping during the last 7 days.

- ☐ 0 – No support provided
- ☐ 1 – Supervision/Cueing only
- ☐ 2 – Setup only
- ☐ 3 – Physical assistance provided
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

6.c. What was the individual's level of unmet need for housekeeping during the last 7 days?

- ☐ A – Need was seldom or never met
- ☐ B – Need was met, no need for additional help
- ☐ C – Unknown

6.d. Housekeeping Comments:

7.a. **LAUNDRY:** During the last 7 days, how would you rate the individual's ability to perform laundry? (Carrying laundry to and from the washing machine, using washer and dryer, washing small items by hand.)

- ☐ 0 - **Independent:** No help provided (With/without assistive devices)
- ☐ 1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐ 2 – **Done by Others:** Full caregiver assistance.
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

7.b. Select the item for the most support provided for laundry during the last 7 days.

- ☐ 0 – No support provided
- ☐ 1 – Supervision/Cueing only
- ☐ 2 – Setup only
- ☐ 3 – Physical assistance provided
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

7.c. What was the individual's level of unmet need for laundry during the last 7 days?

- ☐ A – Need was seldom or never met
- ☐ B – Need was met, no need for additional help
- ☐ C – Unknown

7.d. Laundry Comments:

8.a. **SHOPPING:** During the last 7 days, how would you rate the individual's ability to perform shopping? (Planning, selecting, and purchasing items in a store and carrying them home or arranging delivery if available.)

- ☐ 0 - **Independent:** No help provided (With/without assistive devices)
- ☐ 1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐ 2 – **Done by Others:** Full caregiver assistance.
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

8.b. Select the item for the most support provided for shopping during the last 7 days.

- ☐ 0 – No support provided
- ☐ 1 – Supervision/Cueing only
- ☐ 2 – Setup only
- ☐ 3 – Physical assistance provided
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

8.c. What was the individual's level of unmet need for shopping during the last 7 days?

- ☐ A – Need was seldom or never met
- ☐ B – Need was met, no need for additional help
- ☐ C – Unknown

8.d. Shopping Comments:

Individual's Initials _____

9.a. **TRANSPORTATION:** During the last 7 days, how would you rate the individual's ability to perform transportation? (Safely using a car, taxi, or public transportation.)

- ☐ 0 - **Independent:** No help provided (With/without assistive devices)
- ☐ 1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐ 2 – **Done by Others:** Full caregiver assistance.
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

9.b. Select the item for the most support provided for transportation during the last 7 days.

- ☐ 0 – No support provided
- ☐ 1 – Supervision/Cueing only
- ☐ 2 – Setup only
- ☐ 3 – Physical assistance provided
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

9.c. What was the individual's level of unmet need for transportation during the last 7 days?

- ☐ A – Need was seldom or never met
- ☐ B – Need was met, no need for additional help
- ☐ C – Unknown

9.d. Transportation Comments:

10.a. **CARE OF EQUIPMENT:** During the last 7 days, how would you rate the individual's ability to perform care of equipment? (Cleaning, adjusting or general care of adaptive/medical equipment such as wheelchairs, walkers, nebulizer, IV equipment etc.)

- ☐ 0 - **Independent:** No help provided (With/without assistive devices)
- ☐ 1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐ 2 – **Done by Others:** Full caregiver assistance.
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

10.b. Select the item for the most support provided for care of equipment during the last 7 days.

- ☐ 0 – No support provided
- ☐ 1 – Supervision/Cueing only
- ☐ 2 – Setup only
- ☐ 3 – Physical assistance provided
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

10.c. What was the individual's level of unmet need for care of equipment during the last 7 days?

- ☐ A – Need was seldom or never met
- ☐ B – Need was met, no need for additional help
- ☐ C – Unknown

10.d. Care of Equipment Comments:

Individual's Initials _____

11.a. **CHILD CARE *(ASP Only)*:** During the last 7 days, how would you rate the individual's ability to perform child care? (Bathing, dressing and feeding of own child/children (to the extent that the dependent child cannot perform the tasks for him/herself).

- ☐ 0 - **Independent:** No help provided (With/without assistive devices)
- ☐ 1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐ 2 – **Done by Others:** Full caregiver assistance.
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

11.b. Select the item for the most support provided for child care during the last 7 days.

- ☐ 0 – No support provided
- ☐ 1 – Supervision/Cueing only
- ☐ 2 – Setup only
- ☐ 3 – Physical assistance provided
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

11.c. What was the individual's level of unmet need for child care during the last 7 days?

- ☐ A – Need was seldom or never met
- ☐ B – Need was met, no need for additional help
- ☐ C – Unknown

11.d. Child Care Comments:

12.a. **SUPPORT ANIMALS *(ASP Only)*:** During the last 7 days, how would you rate the individual's ability to perform care of support animal(s). (Feeding, grooming and a minimum of walking of seeing-eye dogs, hearing-ear dogs, or other support animals.)

- ☐ 0 - **Independent:** No help provided (With/without assistive devices)
- ☐ 1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐ 2 – **Done by Others:** Full caregiver assistance.
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

12.b. Select the item for the most support provided for support animal(s) during the last 7 days.

- ☐ 0 – No support provided
- ☐ 1 – Supervision/Cueing only
- ☐ 2 – Setup only
- ☐ 3 – Physical assistance provided
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

12.c. What was the individual's level of unmet need for care of support animal(s) during the last 7 days?

- ☐ A – Need was seldom or never met
- ☐ B – Need was met, no need for additional help
- ☐ C – Unknown

12.d. Support Animal(s) Comments:

Individual's Initials _____

13.a. **MOBILITY GUIDE *(ASP Only)*:** For individuals who are blind or visually impaired, during the last 7 days, how would you rate the individual's ability to get from place to place in and around the home, shopping, and in medical or educational facilities.

☐0 - **Independent:** No help provided (With/without assistive devices)
☐1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
☐2 – **Done by Others:** Full caregiver assistance.
☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

13.b. Select the item for the most support provided for mobility guide during the last 7 days.

☐0 – No support provided
☐1 – Supervision/Cueing only
☐2 – Setup only
☐3 – Physical assistance provided
☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

13.c. What was the individual's level of unmet need for mobility guide during the last 7 days?

☐A – Need was seldom or never met
☐B – Need was met, no need for additional help
☐C – Unknown

13.d. Mobility Guide Comments:

Additional ADL/IADL Comments:

◈*Assessor Action*◈

If an "unmet need" has been identified, arrange for appropriate services and review functional assessment and services as needed.